Book Reviews

Twin and Triplet Psychology: A Multi-Professional Guide to Working With Multiples

Edited by Audrey C. Sandbank
London and New York,
Routledge, 1999, 224 pages,
ISBN 0-41518-397-9, $85.00

Reviewed by Paul Kymissis, M.D.

In this volume, contributing authors from various countries including Sweden, the United Kingdom, Australia, and the United States, and from diverse backgrounds and disciplines including medicine, pediatrics, neuropsychiatry, psychotherapy, and research, examine the very interesting subject of twin and triplet psychology.

Although the current technology of in vitro fertilization has dramatically increased the number of multiple births, there is insufficient literature on the psychological aspects of twins and multiples. This book attempts to fill the gap of knowledge, in theory and practice, about psychological issues pertaining to multiple-birth families.

In the first chapter, the author describes the psychology of twin and triplet relationships and gives insights into how it feels to be a twin. Many of the past studies about twins reared apart (and together) showed the importance of genetic factors in the development of human behavior. This author addresses many of the myths about twins, including "telepathy," explaining that these amazing coincidences and synchronicities are related more to genetics than to telepathic experience.

Many twin pregnancies are considered "at risk," a fact that underscores the vulnerabilities of twins. In her chapter about twins in utero, Piontelli brings new and important information about twin research, which, aided by technologies such as ultrasound, is expanding to study prenatal behavior. Monozygotic twins in utero are never behaviorally identical.

Spillman looks at antenatal and postnatal influences on family relationships. If a mother loses a twin fetus, this can deeply wound the mother and surviving twin. Psychological support is important when dealing with the death of a twin. This chapter describes how clubs for parents and multiples can play a supportive role for the family.

Mogford-Bevan discusses language development in twins. Although language development can be initially delayed, as the twins mature this is no longer an issue of concern. Chapters by Bryan and Preedy discuss twins with special needs and stress the development of special programs to meet the educational needs of the preschool twin.

Akerman discusses the psychology of triplets. She notes that quite often when parents are not anticipating multiple births, they are faced with "uncertainty syndrome"—that is, they are unprepared emotionally and may feel fearful and anxious. Since there are no systematic studies of this population, most of the references come from anecdotal case descriptions.

From the epidemiological studies of multiples, it is noted that 1 out of 7,000 births of non–medically assisted conceptions may be triplets. Triplets can be trizygotic, dizygotic, or—rarely—all identical. In terms of psychopathology, attention-deficit/hyperactivity disorder is more frequent in twins and multiples than in the general population.

Sandbank's chapter on personality, identity, and family relationships is particularly useful. The sense of self in twins balances the tendency to stay the same as one's twin and the desire to become separate.

The book suffers from the usual problem of edited volumes: it lacks conformity among chapters and integration of each aspect of the topic. Such integration could follow issues from basic research to findings, developmental implications, and clinical applications for the everyday clinical practice.

In general, however, the book covers most areas of an important but neglected topic, addressing a phenomenon that is becoming more common with current technological developments in medicine and obstetrics. This book represents an important contribution to the literature on the psychology of multiples and could be useful to clinicians, parents, and teachers.

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Collapse of the Self and Its Therapeutic Restoration

By Rochelle G. K. Kainer
Hillsdale, NJ, The Analytic Press,
1999, 224 pages, ISBN 0-88163-317-8, $34.50

Reviewed by Bertram D. Cohen, Ph.D.

This book is intended to integrate contemporary relational

conceptions of psychoanalytic psychotherapy with the historically earlier drive-theoretic conceptions of Freud and Melanie Klein. The theoretical synthesis is illustrated with examples from literature and the arts, everyday life, and the author's clinical experience. The book's title phrase "collapse of the self" refers to self states in which an individual's sense of self is reduced, at least temporarily, to the confines of a particular set of largely implicit and automatic beliefs about self and others and the behaviors that ordinarily express them. Common examples are the angry "self-as-victim" or the remorseful, redemption-seeking "self-as-offender." During such states, the perception of self and others collapses into the minimal dimensions essential to the self state. The full richness and complexity of self in everyday life are lost during the collapse. A consequence is that other persons in the individual's immediate relational world are, in reaction, themselves susceptible to complementary forms of collapse. For example, a therapist's own sense of self may (no matter how transiently) collapse into the "offender" who feels guilty and ineffectual in reaction to a "victimized" patient's plight.

The author differentiates her concept of "imaginative empathy" from Kohut's[1] "vicarious introspection." She points out that for Kohut, therapists are "objective observers" *at the same time* that they consult their own inner reactivity to their patients. Kainer asserts that this is impossible because therapists are bound to experience a temporary loss of objectivity when reacting sensitively to patients' projections. Her view seems valid to this reader. If so, the difference from Kohut may be that the two attitudes (objective and subjective) occur in alternation rather than simultaneously. The therapist, as the target of a patient's projection, is influenced by his or her own needs in relation to the patient. Yet the therapist can recover, discern what is happening, consider what his or her own role in the process has been, and then respond in a therapeutically useful manner. This is not easy to do. As Kainer's case materials indicate, it requires the courage to "surrender" to the patient's unconscious demands on one's identity (that is, to "hear" the demands, not to carry them out); the confidence that one can survive the storm (not sacrifice one's own identity to the patient's demands); and the ability (of therapist and patient) to harness the energy of the storm's currents in the interest of the self-transformative process.

Kainer's effort to synthesize past and present is as worthwhile as it is problematic. The problems are twofold. The first is how to retain some of the older classical and object-relational facets of psychoanalytic theory without reifying or pathologizing patients and processes. The second is how to incorporate relational and intersubjective approaches into one's practice without losing sight of certain technical limits[2] on therapist expressions of self in the patient–therapist relationship. These constraints once were surely overdone; yet in their current empathically attuned forms, they remain (just as surely) essential.

As to the first problem, retaining aspects of classical theory: when used too freely, terms like "psychotic" tend to pathologize patients in a manner that may sacrifice attunement. That is, terms like "psychotic" or even "sadomasochistic" are essentially *metaphors* when applied to patients who are not clinically psychotic or do not engage in overt acts of sadomasochism. Such metaphors may signify phenomena that overlap with the meanings that comprise their source concepts but are not identical with them. They may contribute affective color to one's clinical or scholarly rhetoric. But, in applying them too liberally, therapists implicitly collapse patients into stereotypical categories, thus tending to distance themselves from their patients' (to say nothing of their own) subjective worlds.

As to the second problem, expression of self: the author's concern for patients' selfobject needs is a highly useful aspect of contemporary psychotherapy. Yet therapists also need to modulate their efforts to sustain attunement to patient needs with a considered awareness of the psychoanalytic meaning of "therapist abstinence."[3] While this feature of the classical approach may once have been seriously overemphasized, it can also be underemphasized. Thus, in one vignette ("Ms. B"), a patient's sensed vulnerability had the therapist walking on eggshells through much of their work together, only to see the patient leave therapy abruptly and prematurely when the therapist suddenly expressed her exasperation with the patient's especially stubborn resistance at that moment in time. The "technical error" here may not have been in the therapist's immediate reaction, as Kainer suggests. Rather, it may have been that she had previously been too careful to support the patient's (and therapist's?) wish to be shielded from openly considering the nature of the patient's persistent implicit demand that the therapist not breach her patient's "prickly" sense of self.

This book is worth reading. The

author is sensitive and candid, willing both to accept and to challenge, to learn and to teach, drawing on both her clinical work and her lively involvement with the world in which she lives.

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Learning Psychotherapy: A Time-Efficient, Research-Based, and Outcome-Measured Psychotherapy Training Program

By Bernard D. Beitman and Dongmei Yue
New York, W.W. Norton, 1999, 350 pages, ISBN 0-393-70296-0, $40.00

Reviewed by Leonard S. Stein, Ph.D.

Although the authors of this important and timely work don't quite succeed in reaching the lofty goals implied in their title, their book is nonetheless a major contribution to the literature. I found it refreshing, exciting, and highly thought-provoking.

Beitman and Yue outline three approaches to the teaching of psychotherapy. First, there is the usual "disorganized" approach of exposing residents to a variety of lecturers, seminar leaders, and supervisors, each presenting his or her own approach. Second, there is the school-based, or in its most oversimplified form, the manual-based approach (usually derived from "experimentally validated treatments"), which has yet to be clearly demonstrated as useful in naturalistic, clinical settings. The authors opt for a third approach that teaches the research-based "common factors" shown by many well-executed studies to be the essential elements in all successful psychotherapies.

The one-year training program is based on a four-stage conceptualization of the psychotherapeutic process: Engagement, Pattern Search, Change, and Termination. The series of 90-minute seminars consists of very brief lectures, a good deal of discussion (much of it based on brief homework assignments), and the watching, rating, and discussion of videotapes.

The program is divided into a pre-training period, six training modules, and post-training. In the pre-training period, the residents receive an overview of the course, rate themselves on a therapeutic "self-estimate" inventory, and are given a number of forms to be filled out by them and their patients before the first therapy session and after the third. The self-estimate inventory, along with a measure of what the residents feel they have learned and where they feel they need additional help, are repeated after each module and at post-training. These self-ratings, along with independent and patient ratings, appear potentially very useful for statistical measurement of the effectiveness of the training program.

The six modules, varying in length and complexity, are devoted to 1) verbal response modes and intentions, 2) working alliance, 3) inductive reasoning to determine patterns, 4) strategies for change, 5) resistance, and 6) transference and countertransference. The emphasis placed on the psychoanalytic concepts in modules 5 and 6 belies the authors' stated attempt to base the program on "research-based" common factors and not on schools. Furthermore, the module on transference and countertransference is the longest, the most highly conceptual, and by far the most complex. It is also not very clearly written and contains a few outright mistakes. On the positive side, this module does contain some quite helpful material, including practical suggestions contained in the sections on managing transference and managing countertransference.

Beitman and Yue state in their module on the working alliance that therapists' personal characteristics are "beyond the influence of training." However, research-based variables such as therapists' accurate empathic understanding, warmth, and affirmation can be taught as important elements in the development of a good working alliance. If the authors would omit the school-based modules and include the most elementary of those concepts within the other modules, additional, more research-based common factors could be included or elaborated on. For example, it would be helpful to add more details about the nature and relative importance of the various pa-

tient factors, external factors, and placebo and expectation factors significantly related to positive outcome, and how best to address or capitalize on these during treatment.

Adding a number of elements to the pre-training section of the program might be useful for residents with relatively little prior psychological training. First, some discussion of the meaning of the biopsychosocial model might be helpful. I have found that many residents grapple with a lack of understanding of the concept of scientific reductionism and therefore have trouble understanding how a mental disorder with demonstrated hereditary predisposition that can be responsive to chemical intervention can also have psychological, interpersonal, familial, social, and cultural components, any or all of which may be crucial to address in treatment. Second, psychiatry residents might benefit from some brief exposure to the literature on effective doctor–patient relationships across various fields of medicine. Third, the training program, and Beitman and Yue's four-stage conceptualization of the psychotherapy process, lend themselves most readily to the treatment of patients who are relatively high-functioning. I would suggest more attention during pre-training to the application of a differential diagnosis to psychosocial treatment planning, along with some measure of ego functioning, to determine whether Stage Four (successful termination) is a reasonable goal for the particular patient being evaluated. One research-based approach to this kind of initial evaluation and planning is that described by Prochaska and his colleagues.[1,2]

In sum, despite some flaws and some areas where there is potential for improvement (including the quality of the editing), this book is an extremely important and timely contribution to the literature, in that it presents the efforts of educators sincerely interested in tailoring a research-based, outcome-measured, and interesting psychotherapy training program to the needs of psychiatry residents. In my opinion, it ought to be read by all directors of psychiatry training programs interested in teaching from a biopsychosocial perspective.

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2. Hubble MA, Duncan BL, Miller SD: The Heart and Soul of Change. Washington, DC, American Psychological Association, 1999

Hysteria

By Christopher Bollas
New York, Routledge, 1999, 208 pages, ISBN 0-41522-032-7, $29.95

Reviewed by Mary Nicholas, LCSW, Ph.D.

In his new book *Hysteria*, Christopher Bollas breaks new ground while skillfully tilling the old. He brings back the once-prevalent diagnosis of "hysteria" and defines it in terms that can help psychotherapists understand a number of high-functioning clients and some more difficult ones as well. Although there has been an overuse of the diagnosis "borderline personality" in the last two decades, sexual neuroses, oedipal issues, and hysteria seem to have faded from view. Freud's typical patient in the early years was frequently hysteric—often female, bright, sexually repressed, bursting with vivid dreams and fantasies, prone to psychosomatic symptomatology. We all have such clients today, do we not? But what do we call them? If they are on the healthier side, they are seen as having adjustment disorders (perhaps eschewing characterological diagnosis altogether), or as having a disorder of the self (self psychological perspective). If more flamboyant or difficult, they are seen as borderline and demoted to preoedipal status, lacking in object constancy and laden with pathological narcissism.

How could such a prevalent diagnosis completely disappear in just a few decades? Showalter,[1] Micale,[2,3] and others have shown that a particular type of psychopathology is a cultural artifact. Hysteria emerged from Victorian culture in which sexual suppression was the norm. First, with more sexual freedom and more freedom for women in general, the need for women in the twentieth century to express their sexuality in bizarre, dissociated ways may have been reduced. Second, some cases once classed as hysteria might today be diagnosed as actual biological illnesses such as bipolar disorder, hyper-or hypothyroidism, epilepsy, or assorted other neurological disorders. Third, the pervasive acceptance of the existence of an unconscious may have reduced the prevalence of somatization of psychological distress (although Showalter[1] argues that

some of the vaguer physical syndromes such as chronic fatigue syndrome are actually hysterical diseases existing on a societal level).

In his quiet psychoanalytic world Bollas has discovered that hysteria is alive and well, and at the root of it is sexual dysfunction that is based not in trauma or sexual abuse, but in a de-eroticization of the self that begins in the early oedipal years in the context of an otherwise loving mother-child relationship. Like the hysteric of yore, the hysteric of today is sexually repressed. Even though she or he may act the part of a sexual person or even in some instances be promiscuous, it is all for show. True sexual gratification is unknown to the hysteric or is accessible only in an inebriated or otherwise altered state of consciousness. The reason for this distancing from sexual feeling is that the mother of the hysteric discouraged and minimized the child's natural sexual curiosity regarding his or her own body, and the mother's, in the early years beginning at around age three. Instead, the mother of the hysteric reveled in the child's verbal and imaginative productions, encouraging performance, charm, and storytelling. The hysteric engages the other and is engaged in every way except the sexual, thriving on the drama of an interaction but lacking the capacity for true physical intimacy.

Unlike the borderline and narcissistic personalities, the hysteric is able to experience the other as a whole object. Even though the hysteric acts as the projection screen for the other, it is entirely for purposes of distancing him- or herself from the sexual pleasure so disapproved of by the mother. Unlike borderline patients, hysterics can maintain high-level jobs for long periods of time and can maintain a relatively consistent therapeutic relationship, albeit frequently characterized by acting out. They pull the therapist into their narratives, often activating powerful countertransferential responses. They fit themselves into the therapist's internal drama, often becoming the character they believe the therapist thinks they are or wants them to be, and they will push boundaries not because of poor self/object differentiation, but because they have learned at mother's knee to act if not for the delight, then at least for the intense interest of the other. The hysteric who becomes a parent behaves as his or her own parent did—attending to and encouraging most aspects of the child except the sexual. Therapy with the hysteric requires finding the authentic self separate from the drama, building sexual awareness through analysis of defenses against it, and setting appropriate boundaries when necessary.

The book is replete with cases from the author's practice, and those familiar with Bollas's other books will appreciate his inimitable empathy and intuition once again. They will also find the language less convoluted than in his previous books. I would recommend *Hysteria* to any therapist interested in the psychotherapeutic treatment of characterological problems.

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